

EHC claim form

DO NOT WRITE IN THIS SPACE. PBC USE ONLY.

Extended Health Care Standard Claim Form



Mailing Address
**PO Box 7000
Vancouver BC V6B 4E1**

Street Address
**4250 Canada Way
Burnaby BC**

- Please read instructions on reverse before submitting this form. Ensure you have completed all sections.
- Enclose all original receipts. Keep a copy of the receipts for your records.
- Please refer to your Pacific Blue Cross ID card for your group, ID and dependent numbers.
- For help completing this form or for more information on your EHC plan, call us at **604 419-2600** or **1 888 275-4672** or check **CARESnet**.

MEMBER INFORMATION

Company name		Member's last name	Member's address	
Group number E	Member's identity number	Member's first name	City/Postal code	Daytime phone number ()
Member's provincial health plan number (Care Card)				

EXPENSE INFORMATION

#	Name of dependent claiming (list in dependent and date order)	Birth date (yyyy/mm/dd)	Dependent number	Type of expense or name of medication (For example, hospital, ambulance, or name of clinic)	Date of each purchase or service or hospital admission and discharge dates (yyyy/mm/dd)	Amount paid	Provider/prescriber of service	Nature of illness or injury
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								

||||➔ Total Claim:

My family is (or, I am) registered with Fair PharmaCare Yes No

Is your claim the result of an accident? If yes, attach accident details. Yes No

Is this a Workers' Compensation (WCB) case? Yes No

Is this an ICBC, or other auto insurance, case? Yes No

Are you seeking damages from a third party? Yes No

Do you or your dependents have other insurance to cover these benefits? Yes No

Name of the other insurance company	
Group number	ID number
Name of member with other insurance company	
Effective date (yyyy/mm/dd)	Cancellation date (yyyy/mm/dd)

Pacific Blue Cross does not return receipts. Please save our *Explanation of Benefits* for income tax purposes. If you also have coverage with another insurance company, make a photocopy of all receipts before sending the originals to Pacific Blue Cross.

I certify that I and/or my dependents incurred these expenses. All information is correct.

I consent to Pacific Blue Cross using this personal information to adjudicate my claim and disclosing this information when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I consent to the personal information provided above being retained, used and disclosed in accordance with the benefit provider's privacy policy.

Note: A copy of the Privacy Policy is contained in your benefits booklet: it is also available on our website at www.pac.bluecross.ca

I also authorize Pacific Blue Cross or its agents access to any relevant information required to adjudicate this claim.

Are any of these expenses due to a medical emergency while you were outside of the province where you live? If yes, please contact Pacific Blue Cross for an *Out of Province* claim form.

If you are claiming for the balance not paid by the other insurance company, include photocopies of your receipts and their payment statement.

X

Member's signature Date

IMPORTANT CLAIMING INFORMATION

Please provide all information requested on both sides of this claim form. Pacific Blue Cross is unable to process incomplete claims.

- 1) Submit all claims with itemized statements and original paid receipts, which indicate:
 - patient's name
 - type of purchase or service
 - date of each purchase or service
 - amount charged for each purchase or service

Pacific Blue Cross is unable to accept photocopies unless you have submitted the original receipts to your other insurance company. If so, attach copies of your receipts and a copy of their payment statement.

- 2) List all expenses in dependent and date order.
- 3) Pacific Blue Cross will only consider paying claims that exceed your deductible. See your plan booklet for information about your plan deductible.
- 4) Claims must be received in our office before the deadline. Claims received after the deadline are not eligible. See your EHC booklet for details.
- 5) Submit your EHC claims regularly (Pacific Blue Cross suggests about every three months). *Do not hold your claims until the claiming deadline.*

Your EHC plan may include a deductible and a reimbursement percentage (for example, \$25 deductible; balance paid at 80%). Check your plan booklet for details.

All BC residents covered by the Medical Services Plan of BC are eligible for Fair PharmaCare benefits. If you have not already done so, please register with Fair PharmaCare in order to maximize your financial eligibility. Expenses paid in part by Pacific Blue Cross may be eligible with Fair PharmaCare and should be submitted to Fair PharmaCare first for their consideration (for example, prosthetic appliances, ostomy supplies). Submit to Fair PharmaCare for payment by March 31 of the year following the service or purchase. When you purchase prescription drugs, your pharmacist submits claims to Fair PharmaCare on your behalf.

To claim for the benefits listed below, see the specific instructions.

Check your plan booklet for a list of eligible benefits and the conditions when these benefits are eligible.

PRESCRIBED DRUGS

- official PharmaCare receipt

SERVICES (physiotherapist, chiropractor, podiatrist, naturopath, massage practitioner)

- type of service
- date of each treatment
- amount charged for each treatment
- therapist's name and phone number

HOSPITAL ACCOMMODATION

- type of room (semi-private, private)
- admission and discharge dates
- daily charge
- a description of any additional charges

AMBULANCE

- reason for taking the ambulance
- date of service
- places ambulance taken from and to
- amount charged

OUT OF PROVINCE MEDICAL EXPENSES

Please contact Pacific Blue Cross for an *Out-of-Province* claim form.

HEARING AIDS

Please check your plan booklet for age restrictions.

REGISTERED NURSES

Along with your receipts, Pacific Blue Cross requires a letter from the attending doctor, indicating the diagnosis, that he or she ordered the nurse's services and why the services are necessary.



ORTHOPEDIC SHOES/ORTHOTICS/ COMPRESSION STOCKINGS

Not all EHC plans cover orthotics, orthopedic shoes and compression stockings. Check your plan booklet or CARESnet.

Orthopedic shoes
Submit:

- your receipts
- prescription from the orthopedic surgeon, doctor, chiropractor or podiatrist indicating the type of shoes prescribed
- orthopedic assessment from the ortho surgeon indicating the diagnosis and the need to prescribe the shoes

Orthotics
Submit:

- your receipts
- prescription from the doctor, podiatrist or chiropractor indicating the diagnosis and the need to prescribe orthotics
- letter from the provider of orthotics indicating that the fabrication of the orthotic was done by taking a non-weight-bearing plaster cast of the patient's feet

Compression Stockings
Submit:

- prescription from the medical doctor indicating the diagnosis and the need to prescribe compression stockings

DENTAL ACCIDENTS

Along with your receipts, Pacific Blue Cross requires from the dentist a detailed list of services performed. We also require the exact date of the accident, the circumstances of the accident and information on any other dental coverage. Include all relevant x-rays.

THIRD PARTY LIABILITY

Your EHC plan does not pay for any benefits if a third party is liable by law. For claims due to an accident, indicate if there is possible third party liability. If yes, contact Pacific Blue Cross for further information.

VISION CARE

Not all EHC plans cover vision care benefits. Check your plan booklet. Submit itemized receipts that show the purchase date and the patient's name.